LYMPHOGRANULOMA VENEREUM

DISEASE REPORTING

In Washington

DOH receives approximately 4 (1993) to 0 (2001) reports of lymphogranuloma venereum per year. Most cases occur among immigrants from, or travelers to, endemic areas.

Purpose of reporting and surveillance

- To assure the adequate treatment of infected individuals in order to curtail infectiousness and prevent sequelae of infection.
- To identify, contact, and treat sexual contacts of reported cases in order to break the chain of transmission.

Reporting requirements

- Health care providers: notifiable within 3 work days
- Hospitals: notifiable within 3 work days
- Laboratories: no requirements for reporting
- Local health jurisdictions: notifiable within 7 days of case investigation completion or summary information required within 21 days

CASE DEFINITION FOR SURVEILLANCE

Clinical criteria for diagnosis

Infection with L1, L2, or, L3 serovars of *Chlamydia trachomatis* may result in a disease characterized by genital lesions, suppurative regional lymphadenopathy, or hemorrhagic proctitis. The infection is usually sexually transmitted.

Laboratory criteria for diagnosis

- Isolation of *C. trachomatis*, serotype L1, L2, or L3 from clinical specimen, or
- Demonstration by immunofluorescence of inclusion bodies in leukocytes of an inguinal lymph node (bubo) aspirate, or
- Positive microimmunofluorescent serologic test for a lymphogranuloma venereum strain of *C. trachomatis*.

Case definition

- Probable: a clinically compatible case with one or more tender fluctuant inguinal lymph nodes or characteristic proctogenital lesions with supportive laboratory findings of a single *C. trachomatis* complement fixation titer of >64.
- Confirmed: a clinically compatible case that is laboratory confirmed.

A. DESCRIPTION

1. Identification

A sexually acquired biovar of *Chlamydia trachomatis*. It begins with a small, painless, evanescent erosion, papule, nodule or herpetiform lesion on the penis or vulva, frequently unnoticed. Regional lymph nodes undergo suppuration followed by extension of the inflammatory process to the adjacent tissues. In the male, inguinal buboes are seen that may become adherent to the skin, fluctuate and result in sinus formation. In the female, inguinal nodes are less frequently affected and involvement is mainly of the pelvic nodes with extension to the rectum and rectovaginal septum, the result is proctitis, stricture of the rectum and fistulae. Proctitis may result from rectal intercourse; LGV is a fairly common cause of severe proctitis in homosexual men. Elephantiasis of the genitalia may occur in either gender. Fever, chills, headache, joint pains and anorexia are usually present. The disease course is often long and the disability great, but generally not fatal. Generalized sepsis with arthritis and meningitis is a rare occurrence.

Diagnosis is made by demonstration of chlamydial organisms by IF, EIA, DNA probe, PCR, culture of bubo aspirate or by specific micro-IF serologic test. CF testing is of diagnostic value if there is a fourfold rise or a single titer of 1:64 or greater. A negative CF test rules out the diagnosis.

2. Infectious Agent

Chlamydia trachomatis, immunotypes L-1, L-2 and L-3; related to the organisms of trachoma and oculogenital chlamydial infections.

3. Worldwide Occurrence

Worldwide, especially in tropical and subtropical areas; more common than ordinarily believed. Endemic in parts of Asia and Africa, particularly among lower socioeconomic classes. Age incidence corresponds with sexual activity. The disease is less commonly diagnosed in women, probably due to frequency of asymptomatic infections; however, gender differences are not pronounced in countries with high endemicity. All races are affected. In temperate climates, it is seen predominantly among male homosexuals.

4. Reservoir

Humans; often asymptomatic (particularly in females).

5. Mode of Transmission

Direct contact with open lesions of infected people, usually during sexual intercourse.

6. Incubation period

Variable, with a range of 3-30 days for a primary lesion; if a bubo is the first manifestation, 10-30 days to several months.

7. Period of communicability

Variable, from weeks to years during presence of active lesions.

8. Susceptibility and resistance

Susceptibility is general; status of natural or acquired resistance is unclear.

B. METHODS OF CONTROL

1. Preventive measures:

Except for measures that are specific for syphilis, preventive measures are those for sexually transmitted diseases. See Syphilis, B1, and Granuloma inguinale, B1.

2. Control of patient, contacts and the immediate environment:

a. Report to local health authority.
b. Isolation: None. Refrain from sexual contact until all lesions are healed.
c. Concurrent disinfection: None; care in disposal of discharges from lesions and of articles soiled therewith.
d. Quarantine: None.
e. Immunization of contacts: Not applicable; prompt treatment on recognition or clinical suspicion of infection. Investigation of contacts and source of infection: Search for infected sexual contacts of patient. Recent contacts of confirmed active cases should receive specific therapy.
f. Specific treatment for adults: Doxycycline 100 mg PO twice a day for 21 days. Alternative regimens: erythromycin base 500 mg PO four times a day for 21 days. Do not incise buboes; drain by aspiration through healthy tissue.

3. Epidemic measures

Not applicable.

4. International measures

See Syphilis, B4.